STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED					
		15G465	B. WING	00	03/03/2021			
		100100			00,00,2021			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT					
COMMU	NITY ALTERNATIN	/ES-ADEPT		NAPOLIS, IN 46250				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	-	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
V 0000								
Bldg. 00	recertification and	the pre-determined full state licensure survey. This wid-19 focused infection	W 0000					
		onjunction with the mplaint #IN00328554.						
	Dates of Survey: F March 3, 2021.	ebruary 22, 23, 24, 25, 26, and						
	Facility Number: (000979						
	Provider Number:							
	Aims Number: 100	0244860.						
	accordance with 4	reflect state findings in 60 IAC 9. this report completed by						
	#15068 on 3/18/21							
V 0159	483.430(a) QIDP							
Bldg. 00	be integrated, co a qualified intelle Based on record re	ve treatment program must ordinated and monitored by ctual disability professional. view and interview for 2 of 3 ients A and B), the QIDP	W 0159	CORRECTION: Each client's active treatment	04/02/202			
	(Qualified Intellec failed to ensure cli	tual Disabilities Professional) ents A and B obtained their cards needed to attend		program must be integrated, coordinated and monitored by qualified intellectual disability				
	required medical a			professional. Specifically: clie and B have obtained identifica				
	Findings include:			documentation to ensure their ability to attend medical				
	Client A's record v	vas reviewed on 2/23/21 at		appointments.				
	9:30 AM. Client A	's record did not indicate		The QIDP will be retrained				
	documentation of	a comprehensive dental		regarding the need to assure				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

PRINTED: 04/06/2021

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 15G465 B. WING 03/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6025 BUCKSKIN CT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) examination completed within 30 days of when new clients are admitted to admission to the group home (admission date for the facility, the team needs to assure that they have all client A was 11/17/20). necessary documentation to Client B's record was reviewed on 2/23/21 at exercise their rights as citizens 10:40 AM. Client B's record indicated a medical and receive required assessments and other services. audit completed on 12/21/20. Client B's medical PREVENTION: audit indicated a dental examination was Members of the Operations Team scheduled for 12/30/20. Client B's record did (comprised of the Executive not indicate documentation of a dental examination completed on 12/30/20. Client B's Director, Operations Managers, medical audit indicated a vision examination was Program Managers, Quality scheduled for 12/29/20. Client B's record did Assurance Manager, QIDP Manager, QIDP, Quality not indicate documentation of a vision examination completed on 12/29/20. Client B's Assurance Coordinators, Area record did not indicate documentation of a Supervisors, Nurse Manager and comprehensive dental examination completed Assistant Nurse Manager) will conduct administrative monitoring within 30 days of admission to the group home (admission date for client B was 11/17/20). during varied shifts/times, to assure interaction with multiple staff, involved in a full range of LPN (Licensed Practical Nurse) #1 was interviewed on 2/25/21 at 9:22 AM. LPN #1 active treatment scenarios. no indicated clients A and B had not attended any of less than weekly until all staff their scheduled vision, hearing, or dental demonstrate competence. After examinations since moving into the group home this period of enhanced in November. LPN #1 indicated she was administrative monitoring and informed by the RM (Resident Manager) the support, the Executive Director clients had not attended any of their scheduled and Regional Director will medical appointments because neither client had determine the level of ongoing obtained their ID's (Identifications cards) needed support needed at the facility. for the appointments. Administrative Monitoring is defined as follows: QIDPM (Qualified Intellectual Disabilities The role of the Professional) Manager #1 was interviewed on administrative monitor is not 2/25/21 at 9:55 AM. QIDPM #1 indicated the simply to observe & Report. facility has been unable to obtain the proper When opportunities for documentation from client A and B's former training are observed, the monitor provider to obtain their ID's. QIDPM #1 must step in and provide the indicated requests were made to the former training and document it. provider for proper documentation at the time of If gaps in active treatment

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PRINTED: 04/06/2021 FORM APPROVED

OMB NO. 0938-0391

Event ID: LWO111

Facility ID: 000979

If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>		
		15G465	B. WING		03/03/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP CODE	•	
COMMU	NITY ALTERNATIV	/ES-ADEPT		BUCKSKIN CT ANAPOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
IAG		ts A and B in November, but	TAG	are observed the monitor is	DATE	
		DPM #1 indicated he was		expected to step in, and mode	el the	
	-	ist request was made.		appropriate provision of suppo		
				· Assuring the health and		
	9-3-3(a)			safety of individuals receiving		
				supports at the time of the		
				observation is the top priority.		
				· Review all relevant		
				documentation, providing		
				documented coaching and		
				training as needed Administrative support at the I	nome	
				will include but not be limited		
				assuring clients have appropri		
				identification documentation.		
				RESPONSIBLE PARTIES: QI	DP,	
				Area Supervisor, Residential		
				Manager, Direct Support Staff	,	
				Operations Team, Regional Director		
V 0210	483.440(c)(3)					
	INDIVIDUAL PRO	OGRAM PLAN				
Bldg. 00	-	fter admission, the				
		eam must perform accurate				
		reassessments as needed to				
	conducted prior t	oreliminary evaluation				
		view and interview for 2 of 3	W 0210	CORRECTION:	04/02/202	
		ients A and B), the facility	W 0210	Within 30 days after admission		
		ent A and B's dietary		the interdisciplinary team mus		
		completed within 30 days of		perform accurate assessment		
		roup home, and client B's		or reassessments as needed		
		ment was completed within 30		supplement the preliminary		
	days of admission	to the group home.		evaluation conducted prior to		
	Dia dia i- 1 1			admission. Specifically, client	A's	
	Findings include:			Comprehensive Functional		
	Client A's record y	vas reviewed on 2/23/21 at		Assessment has been comple		
	9:30 AM.	10110101000000112123121 at		and client A and B have receiv	ved	
	7.30 / MVI.			dietary assessments.		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	DNSTRUCTION	(X3) DATI	E SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMB		IDENTIFICATION NUMBER:	A. BUIL	A. BUILDING 00		COMPLETED		
		15G465	B. WING		<u> </u>	03/03/2021		
				STREET /	ADDRESS CITY STATE ZIP CODE			
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT					
сомми	INITY ALTERNATI	VES-ADEPT			IAPOLIS, IN 46250			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)	
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PR	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	IATE	DATE	
					PREVENTION:			
	Client A's dietary	assessment was dated 2/8/21.			The QIDP will retrained regar	rding		
	Client A's dietary	assessment indicated an			the need to assure that all re	levant		
	original admission			re-assessments are complete	ed for			
	did not indicate a	dietary assessment completed			clients within 30 days of			
		admission to the group home.			admission. For the next 30 da	ays,		
				members of the Operations 7	eam			
	Client A's Function	nal Assessment dated 2021			(comprised of the Executive			
	was reviewed. The			Director, Operations Manage	rs,			
	Functional Assess			Program Managers, Quality				
	sections not comp			Assurance Manager, QIDP				
	Concepts (Attendi			Manager, QIDP, Quality				
	Academic Skills (Assurance Coordinators, Are	a			
	Skills), Section V:			Supervisors, Nurse Manager	and			
	(Meal Preparation			Assistant Nurse Manager) wi				
	Skills), and Sectio			conduct administrative monit	oring			
	Skills (Hazardous			during varied shifts/times, to	-			
	review indicated a			assure interaction with multip	le			
	answer' above sect			staff, involved in a full range				
	indicated a handw			active treatment scenarios, n	0			
	answered' above s	ection VIII. The review did not			less than five times weekly,			
	indicate a complet	ed Functional Assessment for			including at least one weeker	nd		
	client A within 30	days of admission to the group			observation. This monitoring	will		
	home.				occur face to face and via vio	leo		
					conferencing platforms due to	o the		
	Client B's record v	vas reviewed on 2/23/21 at			need to contain the spread o	f		
	10:40 AM.				COVID-19. After 30 days,			
					administrative monitoring will			
	Client B's dietary	assessment was dated 2/8/21.			occur no less than three time	S		
	Client B's dietary	assessment indicated an			weekly until all staff demonst	rate		
	original admission	date of 11/19/20 (sic)			competence. After this period	d of		
	(record indicated a	ctual admission date of			enhanced administrative			
	11/17/20). The rev	iew did not indicate a dietary			monitoring and support, the			
	assessment comple	eted within 30 days of			Executive Director and Region	onal		
	admission to the g			Director will determine the let	vel of			
					ongoing support needed at th	ne		
	QIDP (Qualified I	ntellectual Disabilities			facility.			
		vas interviewed on 2/24/21 at			Administrative Monitoring is			
		#1 indicated client A's			defined as follows:			
	-	ment was not completed. QIDP			• The role of the			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER: 15G465	A. BUILDING B. WING	00	COMPLETED 03/03/2021	
	PROVIDER OR SUPPLIE		6025 E	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLET	
TAG	 #1 indicated he tho Assessment was to 90 days of admissia #1 indicated he sho sections of the Fun first 30 days of clie was asked about th initial dietary asses initial dietary asses within the first 30 d admission to the gr client A and client were not completed admission. LPN (Licensed Pra interviewed on 2/2, indicated an initial admission to the gr completed within 3 admission date to t stated, "I initially r for both clients in I (dietician) never re new dietician, and within the approprii QIDPM (Qualified Professional Manag 2/25/21 at 9:55 AM initial dietary assess the group home sho days of the original home. QIDP #1 ino dietary assessments 	A LSC IDENTIFYING INFORMATION) ught the Functional be completed within the first on to the group home. QIDP ould have completed all ctional Assessment within the ent A's admission. QIDP #1 e completion of a client's sment. QIDP #1 indicated the sment should be completed lays of a new client's oup home. QIDP #1 indicated B's initial dietary assessments 1 within the first 30 days of ctical Nurse) #1 was 5/21 at 9:22 AM. LPN #1 dietary assessment for a new oup home should be 0 days of the original he group home. LPN #1 equested a dietary assessment November, however she sponded and then we got a that is why they weren't done ate time." Intellectual Disabilities ger) #1 was interviewed on 1. QIDPM #1 indicated an sment for a new admission to ould be completed within 30 a dmission date to the group dicated client A and B's initial s were not completed within the admission to the group	TAG	administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the mon must step in and provide the training and document it. · If gaps in active treatme are observed the monitor is expected to step in, and model appropriate provision of suppo · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documented coaching and training as needed Administrative oversight will include assuring that all releva re-assessments are completed clients within 30 days of admission. RESPONSIBLE PARTIES: QIE Area Supervisor, Residential Manager, Direct Support Staff, Health Services Team, Operat Team, Regional Director	nt I the rts. DP,	

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 04/06/2021

 FORM APPROVED

 OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 15G465 B. WING 03/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6025 BUCKSKIN CT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 0249 483.440(d)(1) PROGRAM IMPLEMENTATION Bldg. 00 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and W 0249 CORRECTION: 04/02/2021 interview for 3 of 3 sampled clients (clients A, As soon as the interdisciplinary B, and C), the facility failed to ensure clients A, team has formulated a client's B, and C's goals of meal preparation in their ISPs individual program plan, each (Individual Support Plans) were being client must receive a continuous implemented. active treatment program consisting of needed Findings include: interventions and services in sufficient number and frequency Observations were conducted at the group home to support the achievement of the on 2/22/21 from 2:45 PM through 6:19 PM and objectives identified in the on 2/23/21 from 6:30 AM through 8:02 AM. On individual program plan. Through 2/22/21 at 4:19 PM, AS (Area Supervisor) #1 observation, the team determined began preparing the evening meal. Clients A and this deficient practice may have B left on an outing at 5:04 PM. No prompting or affected all clients. Specifically, all encouragement of clients A, B, and C's facility direct support and participation in dinner meal preparation was supervisory staff will be retrained observed before clients A and B left on the regarding proper implementation outing or for client C throughout the observation. of clients' prioritized learning meal At 5:36 PM, AS #1 completed the dinner meal preparation goals, when preparation independently. applicable and the need to provide informal meal preparation training Client A's record was reviewed on 2/23/21 at to all clients. 9:30 AM. Client A's ISP (Individualized Support **PREVENTION:** Plan) dated 12/15/20 indicated client A had a The facility's QIDP will be trained goal to prepare a side dish at meal time with the regarding the need to assure assistance of staff. Client A's ISP indicated client aggressive and consistent A did not know how to cook and he would like to implementation of active treatment learn how to prepare a simple dish. for all clients. A management staff will be

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1 Facility ID: 000979

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION (>	(3) DATE SURVEY		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED		
		15G465	B. WING	<u></u>	03/03/2021		
			STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF	PROVIDER OR SUPPLIE	ČR.		SUCKSKIN CT			
СОММІ	JNITY ALTERNATI	VES-ADEPT		APOLIS, IN 46250			
	•			1			
X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE		
		vas reviewed on $2/23/21$ at		present, supervising active			
		B's ISP dated 12/15/20		treatment during no less than five	/e		
		had a goal to prepare a side		active treatment sessions per			
		with assistance of staff. Client		week, on varied shifts to assist			
		ne did not know how to cook		with and monitor implementation			
		learn how to prepare a simple		of prioritized goals and informal			
	dish.			training, as well as proper	ra		
	Client Cl 1	vas reviewed on 2/23/21 at		intervention with target behavior			
				Members of the Operations Tea	arn		
		C's ISP dated 4/14/20		(comprised of the Executive			
		had a goal to prepare a side		Director, Operations Managers,			
		with assistance of staff. Client		Program Managers, Quality			
		ne did not know how to cook		Assurance Manager, QIDP			
		learn how to prepare a simple		Manager, QIDP, Quality			
	dish.			Assurance Coordinators, Area			
				Supervisors, Nurse Manager an	ia		
	· ·	sor) #1 was interviewed on		Assistant Nurse Manager) will			
		M. AS #1 indicated the clients		conduct administrative monitorin	ng		
	-	ch include assisting with meal		during varied shifts/times, to			
		indicated they should have		assure interaction with multiple			
		buraged the clients to assist		staff, involved in a full range of			
	with the meal prep	paration on 2/22/21.		active treatment scenarios, no			
	OIDD (Outlife d I			less than weekly until all staff			
		ntellectual Disabilities		demonstrate competence. After this period of enhanced			
	,	as interviewed on 2/24/21 at #1 was asked about meal					
		hy client A, B, and C's goal of		administrative monitoring and support, the Executive Director			
		side dish was not run on					
		indicated meal preparation		and Regional Director will determine the level of ongoing			
	-	based activity in which the		support needed at the facility.			
		nvolved in if they desire. QIDP		Administrative Monitoring is			
		should have prompted the		defined as follows:			
		th meal preparation, and only		• The role of the			
		lone if the clients refused to		administrative monitor is not			
	participate.	ione il ule chemo refused to		simply to observe & Report.			
	pur norpato.			• When opportunities for			
	OIDPM (Qualified	l Intellectual Disabilities		training are observed, the monit	for		
		ger) #1 was interviewed on		must step in and provide the			
		M. QIDPM #1 indicated with		training and document it.			
		s goal of meal preparation,		· If gaps in active treatmen	t I		
		5 50 or mean proparation,	1		•		

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G465		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 03/03/2021	
	PROVIDER OR SUPPLIE		6025	T ADDRESS, CITY, STATE, ZIP CODE BUCKSKIN CT ANAPOLIS, IN 46250	DE	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	they should have b	een prompted and encouraged e dinner meal preparation.		are observed the monitor is expected to step in, and mod appropriate provision of supp · Assuring the health ar safety of individuals receivin supports at the time of the observation is the top priority · Review all relevant documentation, providing documented coaching and training as needed Administrative support at the will include meal preparation training. RESPONSIBLE PARTIES: C Residential Manager, Direct Support Staff, Operations Te Regional Director	ports. g /. e home QIDP,	
W 0323 Bldg. 00	The facility must physical examina minimum include hearing. Based on record re sampled clients (c ensure client C have examinations com Findings include: Client C's record w 11:41 AM. Client	HYSICIAN SERVICES e facility must provide or obtain annual ysical examinations of each client that at a nimum includes an evaluation of vision and aring. used on record review and interview for 1 of 3 mpled clients (client C), the facility failed to sure client C had current hearing and vision aminations completed. W 0323 minuminations completed. W 0323 minuminations completed. The facility must provision are examinations of each at a minimum includes evaluation of vision are specifically, client B wisual and audiological examinations. An auditional completed is the facility in the indicate	The facility must provide or obtain annual physical examinations of each client to at a minimum includes an evaluation of vision and heat Specifically, client B will rece visual and audiological examinations. An audit of fac	ring. eive cility	04/02/202	
	examination. QIDP (Qualified I Professional) #1 w	ntellectual Disabilities as interviewed on 2/24/21 at #1 indicated they currently do		medical charts indicated this deficient practice did not affe additional clients. PREVENTION: • The Facility nurse will complete monthly audits of a	ect	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 15G465 B. WING 03/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6025 BUCKSKIN CT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) not have documentation of client C's current charts and turn in the audits to the hearing or vision examinations. Nurse Manager for review. The Nurse Manager will review issues revealed in audits LPN (Licensed Practical Nurse) #1 was interviewed on 2/25/21 at 9:22 AM. LPN #1 with the Executive Director and indicated client C's hearing and vision Department heads weekly for follow-up. examinations had been scheduled but they were missed and she was unaware why they were The Executive Director and will follow-up with the Nurse missed. Manager as needed to address **OIDPM** (Oualified Intellectual Disabilities issues raised through audits, Professional Manager) #1 was interviewed on incident reports or other concerns 2/25/21 at 9:55 AM. QIDPM #1 was asked about brought to management attention. Members of the Operations Team documentation of client C's current vision and (comprised of the Executive hearing examinations. QIDPM #1 stated, "If there was no documentation in the file and the nurse Director, Operations Managers, was not able to provide documentation, then we Program Managers, Quality Assurance Manager, QIDP do not have it." Manager, QIDP, Quality 9-3-6(a) Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that medical follow-along including but not limited to visual examinations take place as reauired. **RESPONSIBLE PARTIES: QIDP,** Area Supervisor, Residential Manager, Heath Services Team, **Direct Support Staff, Operations** Team, Regional Director W 0351 483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC Bldg. 00 SERVICE

FORM CMS-2567(02-99) Previous Versions Obsolete

Comprehensive dental diagnostic services

Event ID: LWO111

O111 Facility ID: 000979

000979 If

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PRINTED: 04/06/2021 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 15G465 B. WING 03/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6025 BUCKSKIN CT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). Based on record review and interview for 2 of 3 W 0351 CORRECTION: 04/02/2021 sampled clients (clients A and B), the facility A complete extraoral and failed to ensure clients A and B had a intraoral examination, using all comprehensive dental examination completed diagnostic aids necessary to within one month of admission. properly evaluate the client's condition not later than one Findings include: month after admission to the facility. Specifically, the facility Client A's record was reviewed on 2/23/21 at has acquired appropriate 9:30 AM. Client A's record did not indicate identification documentation and documentation of a comprehensive dental will obtain dental evaluations for examination completed within one month of clients A and B. A review of admission (admission date of 11/17/20). facility medical records indicated this deficient practice did not Client B's record was reviewed on 2/23/21 at affect other clients. 10:40 AM. Client B's record did not indicate **PREVENTION:** documentation of a comprehensive dental The Health Services Team will examination completed within one month of work with The Residential admission (admission date of 11/17/20). Manager, QIDP and facility Medical Coach to assure that all QIDP (Qualified Intellectual Disabilities relevant assessments, including Professional) #1 was interviewed on 2/24/21 at but not limited to dental 11:30 AM. QIDP #1 indicated they did not have examinations, are completed for documentation of a comprehensive dental clients within 30 days of examination completed for clients A and B. admission and as needed but no QIDP #1 stated, "From what I have gotten from less than annually thereafter. nursing, they had these appointments just prior to Members of the Operations Team moving to the group home in November, and we (comprised of the Executive are trying to retrieve these items from their Director, Operations Managers, former providers." Program Managers, Quality Assurance Manager, QIDP LPN (Licensed Practical Nurse) #1 was Manager, QIDP, Quality interviewed on 2/25/21 at 9:22 AM. LPN #1 Assurance Coordinators, Area

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G465		A. BUILDING 00		COMPLETED		
		B. WING		03/03	3/2021	
	PROVIDER OR SUPPLIE		6025 B	ADDRESS, CITY, STATE, ZIP COD UCKSKIN CT JAPOLIS, IN 46250	E	
X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		TION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL	LD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF		DATE
	indicated the facili	ty does not have		Supervisors, Nurse Mana	ger and	
	documentation of a comprehensive dental			Assistant Nurse Manager) will	
	examination comp	eted clients A and B. LPN #1		follow up with the QIDP n	o less	
	indicated she had scheduled appointments for			twice weekly when new c		
	·	ehensive dental examinations		admitted to the facility to		
		had been told they have been		appropriate assessment of		
	Ũ	ent's identification cards,		required. Prior to admittin	•	
		on the appointments had not		clients, the Program Man	•	
	occurred.			and/or QIDP Manager wil		
				the QIDP with developing		
	QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on			schedule to assure that a		
				necessary assessments of		
		1. QIDPM #1 indicated the			•	
		and B to each have an		Area Supervisor, Resider		
		to attend their comprehensive		Manager, Heath Services		
	dental examinations was not initially communicated to administration causing the delay in obtaining the identification cards and			Direct Support Staff, Ope	rations	
				Team, Regional Director		
		ppointments. QIDPM #1				
		been working on obtaining the				
	the proper documentation to get client A and B's identification cards from their former provider.					
		i nom men ionner provider.				
	9-3-6(a)					

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